HIPAA Authorization for Use and Disclosure of Protected Health Information (PHI)

This authorization allows Midwest Retina Consultants to use or disclose protected health information (PHI)
in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable Illinois privacy laws.

Patient Information

Patient Name: _____
Date of Birth: _____
Address: _____
Phone: _____

Authorization for Disclosure

I authorize Midwest Retina Consultants to release and/or obtain my protected health information to/from:
Name/Organization: _____
Address/Phone: _____
☐ All health information
☐ Billing and insurance information only
☐ Specific records (please specify): _____
Purpose of disclosure: ☐ Treatment ☐ Payment ☐ Legal ☐ Personal ☐ Other: _____

Verbal Communication Authorization

I authorize Midwest Retina Consultants to discuss my medical information verbally with the following individual(s):
Name(s): _____
Relationship(s): _____
☐ I do not authorize verbal communication with anyone.

Electronic Communication Consent

I consent to receive communication about my health information by:
☐ Email: _____
☐ Text Message (SMS): _____
I understand that unencrypted email and text messages may not be secure.

Expiration and Revocation

This authorization expires one (1) year from the date of signature unless specified otherwise: _____.
I understand I may revoke this authorization at any time by submitting a written request to Midwest Retina Consultants.
Revocation will not affect any disclosures made before the date of revocation.

Redisclosure Notice

Information disclosed under this authorization may be subject to redisclosure by the recipient
and may no longer be protected under HIPAA privacy regulations.

Signature

Patient/Authorized Representative Signature: _____ Date: _____
Relationship to Patient (if applicable): _____
Witness/Staff Signature: _____ Date: _____